Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN379AGC	A. BUILDING _____ B. WING _____	C 04/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY FAMILY HOME CARE	1885 CASTLE WAY RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from March 25, 2009 through April 1, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and two employee files were reviewed. Complaint #00021347 was substantiated. The following deficiencies were identified:	Y 000		
Y 085 SS=F	449.199(1) Staffing-CG on duty all times NAC 449.199 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility.	Y 085		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 085	Continued From page 1 This Regulation is not met as evidenced by: Based on record review and interview on March 25, 2009 through April 1, 2009, the administrator failed to ensure that a sufficient number of caregivers were on duty. Findings include: The facility staffing schedule for March 2009 was reviewed. The schedule indicated that Employee #1 and Employee #2 were both scheduled simultaneously for the time period of March 2, 2009 through March 22, 2009. The facility administrator was interviewed and stated she was out of the country during that specific time period. She stated that Employee #1 worked from 9:00am though 5:00pm daily during that time period and that Employee #2 lived at the facility during that time period and was there all the time. The administrator stated that the residents were never left alone. The administrator stated she would call often and there was always a caregiver on duty. Documentation from other state employees indicated that the facility staff were interviewed on 3/17/09 and 3/18/09 and revealed that the residents were sometimes left alone after 5:00pm. A further interview of staff was conducted on April 1, 2009. The interview confirmed that the residents were left alone at times, after 5:00PM during the administrator's absence. Severity: 2 Scope: 3	Y 085		